

February 2004

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Recommended Citation

Saidi, Emmanuel (2004) "Catholic Teaching on Life and the Challenge of the HIV/AIDS Crisis in Sub-Saharan Africa," *The Linacre Quarterly*: Vol. 71: No. 1, Article 3.

Available at: <http://epublications.marquette.edu/lnq/vol71/iss1/3>

Catholic Teaching on Life and the Challenge of the HIV/AIDS Crisis in Sub-Saharan Africa

by

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I. Introduction

As the HIV/AIDS situation in sub-Saharan Africa (sSA) goes on, families, institutions and governments face difficult decisions as to allocating resources toward the care of those suffering from diseases. Countries within sSA follow the British model of socialized medicine. Although private institutions operate centers of health care, eighty-five percent of the people in these countries depend solely on the government plan for their health care.¹ Unlike developed countries (e.g., the United States) where AIDS has evolved into a chronic disease,² in sSA AIDS is an end-stage terminal illness. With skyrocketing infection rates, communities in this region must balance their expenses meeting health care needs against the need to develop the infrastructure, food production and educational systems for the sake of future generations. The health care delivery systems in these regions are in crisis due to inadequate funding, scarcity of trained personnel, inadequate clean water supplies, high population growth, poor hygiene, high levels of illiteracy and poverty.³

Drawing from Catholic teaching, this paper acknowledges that these communities are obliged to provide pain relief for these victims. For reasons that will be studied in detail, treatments beyond this should be regarded as extraordinary, and therefore not an obligation. This is based on the fact that ordinary means of treatment are relative to the availability of resources. The resources in the sub-Saharan region are not sufficient to provide any treatment beyond pain relief.

This paper's focus is on Catholic teaching pertaining to morally necessary measures to prolong life in the HIV/AIDS epidemic in sub-Saharan Africa. The discussion will begin with the development of Catholic teaching on prolonging life and will continue with the principles of ordinary and extraordinary means. Then, these principles will be applied to the socioeconomic conditions in sSA.

II. Development of Catholic Principles of Life Prolonging Measures

The present magisterial teaching of the Catholic Church on prolonging life has developed from the work of 16th and 17th century theologians.⁴ Church teachings have gained a new sense of moral importance, particularly in light of 20th century medical advances that successfully treat illnesses that previously were fatal. This renewed focus resulted in the development of present day magisterial declarations that provide guidance on moral situations involving treatments to prolong life.

One of the earliest Church teachings on measures to prolong life was that of the 16th century Spanish Dominican theologian Francisco de Vitoria. He addressed the issue of when the refusal of food by an ill person violates the natural law obligation to preserve one's life.⁵ De Vitoria argued that if taking food held out the hope of prolonging an ill person's life, then that person is morally obligated to take food. However, if the illness has so depressed the person's spirit that taking food would be torturous, then eating is considered a moral impossibility. Under those circumstances, de Vitoria taught, refusing to eat is not a mortal sin, especially where there is little possibility that life will be extended.⁶ He further taught that one's obligation to eat does not create an obligation to obtain specific foods that may be expensive or difficult to obtain, even if by obtaining these foods, a person's life could be extended.⁷ De Vitoria's final teaching on prolonging life also discusses the use of pharmaceutical treatments. In this teaching, de Vitoria suggests that a person is not morally obligated to take every possible measure to conserve life. The obligation to accept treatment has limits. One is not obligated to expend the family assets on a treatment that will prolong life but not cure the disease. Nor is one obligated to accept a novel treatment because of the possibility that it could extend one's life. The obligation is simply to accept those commonly available remedies. For de Vitoria, then, the obligation to accept medical treatment turns on the treatment's costs and effectiveness.

De Vitoria's teachings have become fundamental principles of Catholic teaching on prolonging life. For example, the Catholic Church teaches that life is a gift from God and one is required to take normal measures to preserve one's life. However, it recognizes certain circumstances in which this obligation becomes a moral impossibility, for

example, where there is great fear, danger, or burden. As a result, the person is excused because the obligation is deemed excessively difficult to meet.⁸ Further, the Church teaches that one's obligation to preserve life is a limited obligation. There is no obligation to employ all possible means necessary to prolong one's life, but only those commonly available and financially affordable. Also, the obligation to seek out treatment is limited to those treatments that provide a reasonable hope of the benefit of returning one to a normal healthy state.

One of the later theologians who expanded the teaching of de Vitoria was a Dominican theologian, Domingo Banez (1528-1604), who introduced the concepts of "ordinary and extraordinary" in the assessment of the morality of prolonging treatment. Banez argued that an individual is responsible for preserving life by "common food and clothing, common medicines, a certain common and ordinary pain; not, however, to a certain extraordinary and horrible pain, nor to expenses which are extraordinary in proportion to the status of this man."⁹ Even though there have been critics¹⁰ of the ordinary and extraordinary distinction, the use of these concepts has continued to be an important aspect of the debates on prolonging life.

The ordinary-extraordinary principle continued to be developed through the teachings of the Spanish theologian, Cardinal John de Lugo. De Lugo taught that preserving one's life is a moral obligation. Not to do so is equivalent to taking one's own life. De Lugo's teachings differed from those of his predecessors in one important aspect. He taught that when treatment does not provide reasonable hope of benefit, then there is no obligation to accept even ordinary treatment.¹¹ De Lugo further teaches that there is never an obligation to accept extraordinary means to preserve one's life, regardless of the possible benefit.¹² For de Lugo, there is a distinction between contributing to your death by refusing ordinary treatments and allowing deaths to occur by refusing extraordinary treatments.¹³ The first is immoral under certain circumstances, and the second is not. De Lugo's teachings laid the foundation for the modern day distinction between suicide and euthanasia and allowing death to occur. Further, de Lugo's teachings also established the relativity¹⁴ of what is ordinary and extraordinary because it is determined, in part, by one's financial circumstances and geographic location, as well as advances in medical treatment.

Following de Lugo's contributions, the debate on prolonging life did not receive much attention until the 20th century Jesuit theologian Gerald Kelly addressed it in his influential writings. Kelly's contributions to the debate included defining the terms "ordinary" and "extraordinary" treatments. Ordinary treatments included those treatments that were obtainable without great difficulty. Extraordinary treatments included those that were excessively difficult to obtain, repugnant, or expensive. "In other

words, an extraordinary means is one which prudent men would consider at least morally impossible with reference to the duty of preserving one's life,"¹⁵ Like de Lugo, Kelly argues that there is no moral obligation to accept ordinary treatment when there is little hope of benefit.¹⁶

Kelly's definition of ordinary and extraordinary treatment became widely accepted when Pope Pius XII adopted Kelly's definitions in his 1957 address to the International Congress of Anesthesiologists. In this address, Pope Pius drew heavily on the works of Vitoria, Banez, de Lugo and Kelly. He stated:

Natural reason and Christian morals say that man (and whosoever is entrusted with the task of taking care of his fellow man) has the right and duty in case of serious illness to take the necessary treatment for the preservation of life and health... But normally one is held to use only ordinary means — according to circumstances of persons, places, times and culture — that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult. Life, health, all temporal activities are in fact subordinated to spiritual ends. On the other hand, one is not forbidden to take more than the strictly necessary steps to preserve life and health, as long as he does not fail in some more serious duty.¹⁷

Therefore, according to Pius XII, there are circumstances in which it may be immoral to seek out extraordinary treatments in order to preserve one's life. For example, if an ill person is married, with young children, and the extraordinary treatment available would result in the devastation of the family's finances, to the extent that there would be no ability to provide for the minor children, obtaining the extraordinary treatment would be immoral, unless there is a high probability the treatment will return the ill person to health. Pius XII also introduced another important component of modern Church teaching. The obligation to preserve and advance one's physical well being is not greater than the obligation to preserve and advance one's spiritual relationship with God. To the extent that preserving life diminishes one's spiritual relationship, then the preservation of physical life becomes an immoral act.

Pius XII's teachings imply that medical treatment is to be evaluated in the context of the patient's overall medical condition and the patient's ability to pursue a spiritual relationship. Therefore, ordinary treatment is that which offers a reasonable hope of benefit and does not diminish one's ability to engage in a relationship with God and does not impose an excessive burden on the family of the ill person. Treatment that meets these qualifications imposes a moral obligation on the ill person to accept.

The Church teaching on prolonging life received further attention in the *Declaration on Euthanasia*, drafted in 1980 by the Congregation For the Doctrine of the Faith (CDF). The extent to which the early writings of Vitoria, Banez and de Lugo had influenced the Church is clearly seen in the Declaration's teaching. In this Declaration, the terms "ordinary" and "extraordinary" were replaced with the terms "proportionate" and "disproportionate." However, as used, the terms are synonymous. As analyzed by CDF, the complexity, risk, and cost of treatment must be considered in determining whether a treatment is proportionate or disproportionate. Also, the degree of possible benefit to the patient that use of the treatment will afford must be determined. Further, the patient's financial resources must be a critical part of the analysis in determining whether a proposed treatment is proportionate or not. Finally, CDF states as an absolute that when death is imminent, withholding or removing life support treatment is acceptable when continuing treatment would "only secure precarious and burdensome prolongation of life."¹⁸

In short, Catholic teaching regards human life as a gift that imposes a responsibility on the individual to care for it. The responsibility commands upon people the duty to apply medical measures or treatments that conserve life.¹⁹ However, the teaching does not advocate for the piteous and expensive prolongation of life through new medical advancements, "once the summons to eternity is clear and final."²⁰ Applied to terminal illness that has no hope of a cure, Church teaching then holds that there is no moral obligation to receive treatment merely to delay death for a short time.

III. Ordinary and Extraordinary Treatment and the Futility Debate

In the previous section we discussed the historical development of the Church's teaching on prolonging life. In this section we will focus more closely on the meaning of the terms "ordinary" and "extraordinary" and use them to evaluate the debate on treatment futility. This discussion will lay the framework for our later discussion on which treatments are to be categorized as ordinary and extraordinary in the context of the HIV/AIDS epidemic in sSA.

A. Ordinary Treatment

Ethical considerations of which treatments are determined to be ordinary focus on the treatments' potential benefits to the patient and the burden imposed through obtaining the treatment. In determining the potential benefit of a treatment, the focus must be on the good of the patient as a whole, and not just what is good for this or that organ system individually. As stated by Gerald Kelly, ordinary treatments "are all medicines, treatments, and operations which offer reasonable hope of

benefit for the patient and which can be obtained and used without excessive expense, pain, or other inconvenience."²¹ While it is clear that medical treatment must provide a hope of benefit before one is obligated to accept it, the sticking point is understanding what is meant by "reasonable hope of benefit." Kelly's writings show that defining the term is not an easy task.²² Kelly offers some guidance in that he seems to emphasize the need to focus on benefit to the patient as a whole as the first determinant of what is to be considered ordinary or extraordinary treatment as opposed to the particular illness being treated.²³ Church teaching on this issue is less clear. However, from the medical perspective, a treatment is beneficial when it restores one's health, relieves one's pain, improves one's physical mobility, returns one to consciousness, enables one to communicate with others, and so on.

Catholic teaching also recognizes all of these as beneficial, but it specifies that for a treatment to be beneficial, it must improve one's physical, mental and emotional condition to the point that one is able to pursue the spiritual goods of life, at least at a minimal level without experiencing significant burdens. In determining whether the burdens experienced as a result of accepting treatment are significant, it is necessary to view the quality of life the patient will experience during and as a result of the treatment, its costs and the ease of access to the treatment, and the financial condition of the patient's family.²⁴ In short, the treatment is burdensome unless it is obtainable with relative convenience.²⁵

B. Extraordinary Treatment

The essential element of extraordinary treatment is the matter of what constitutes a moral impossibility for human beings in general or for a particular person in a given circumstance. There are five general elements to be considered in determining whether treatment is extraordinary. The first is whether the treatment is impossible to obtain or whether the ability to use it is unattainable. The second is whether the treatment requires excessive effort. An example would be undergoing a long journey or enduring a long and burdensome convalescence. The third element is whether the treatment requires a patient to endure considerable pain and discomfort. An example of this is when a patient is going through chemotherapy. The fourth element to be considered is whether the treatment is excessively expensive, taking into consideration the patient's economic status and country of origin. This fourth consideration is subject to criticism because it fails to advocate for equal access to health care by all persons. The final element is whether the treatment causes the patient fear or repugnance to such a degree that it is burdensome for the patient to endure the treatment. Amputation procedures and, in some cultures, receiving treatment from female doctors are examples where fear and

repugnance can render a treatment extraordinary. While the pain factor in amputation procedures has been alleviated through modern medical techniques, repugnance at the idea of living with a mutilated body would still make the procedure extraordinary for some, especially in situations where a disabled individual is a burden to his or her family.

In short, judging whether a means is extraordinary or not requires an evaluation of the treatment's effectiveness, the burden on the patient, and the burden on his or her community. This evaluation requires an inquiry into the patient's emotions and whether the patient and the community have the means to acquire the treatment without denying others access to basic necessities. Examples of such include education, food and shelter. Therefore, an evaluation of extraordinary means includes an understanding of a patient's responsibility to seek out reasonable care and not to seek out care that would require the patient to forsake his or her obligations to others. In situations where a patient is determined to seek out extraordinary treatment at the expense of his or her obligations to others, and the patient's finances cannot cover treatment expenses, then it can be argued that the financier of the treatment has an equal obligation to determine whether, in light of all elements discussed, the treatment is extraordinary. One element to be considered by a third-party financier is whether payment of another's AIDS-related medical expenses will deplete the financier's resources to the point that he or she is unable to meet other responsibilities, such as food, lodging, clothing and education for other family members. If it is determined to be extraordinary, then the financier has a moral obligation to withhold funds.

C. Medical Futility

At least in the United States, contemporary ethical futility debates have surfaced because factors such as quality of life, cost containment, gender, wealth, and patient's age impact physicians' decisions to withhold or withdraw treatments.²⁶ Often these decisions would be made without involving the patient or the family. Because of the manner in which futility decisions had been made by physicians, both the public and patient autonomy advocates began expressing increased concern over the need to develop a clear working definition of medical futility that included the required involvement of patients or guardians.²⁷ The need for a comprehensive medical futility definition has taken on renewed emphasis in the present environment of medical malpractice litigation.

The term "futility" derives from the Latin word *utilis*, meaning something that cannot achieve the desired effect through an intrinsic failure. Because of the inability to affect the desired objective, the action is useless. In the context of medical treatment, there is no clear consensus on a definition for medical futility. The concern is that by defining the term, a

doctor's ability to apply his or her knowledge and experience to a medical condition and determine the best course of action to be followed will be undermined. If a treatment were to fall within an adopted futility definition, then it is possible that a doctor would be prevented from using it.

While no formal definition exists, many medical associations have applied their collective experience in providing guidance as to what types of treatment would be futile. For example, focusing solely on cardiopulmonary resuscitation (CPR), the American Thoracic Society believes that CPR is a futile treatment in those circumstances when, in all probability, its application will not result in a meaningful survival for the patient.²⁸ The American Medical Association (AMA) Council on Judicial and Ethical Affairs differs from the Thoracic Society. The AMA Council considers CPR to be futile when it fails to achieve its physical intended purpose, restoration of cardiac activity.²⁹

The debate regarding what is considered a futile treatment is illustrated in the above examples. For the Thoracic Society, the focus is on qualitative results. The AMA focuses on the quantitative results. Another definition focuses on the probability of success, citing those treatments employed to "achieve a result that is possible but that reasoning or experience suggests is highly improbable and that cannot be systematically produced."³⁰ Others consider futile treatments to be those through which the pain and suffering experience makes the treatment more burdensome than beneficial.³¹

Two renowned bioethicists, Tom L. Beauchamp and James F. Childress, suggest that a futile treatment is one that has no possibility of being efficacious or is not capable of producing a desired effect.³² These authors implicitly incorporate the burdensome, quantitative and qualitative perspectives of other physicians and ethicists into their concept of efficaciousness.³³ In this way, it is the most encompassing proposed definition for futile medical treatment. Regardless of which model you apply, there is a general consensus that in pronounced cases of futile medical treatment, where the treatment will not even achieve the desired physical result, a physician is not morally or legally bound to provide it.³⁴

Some writers argue that not only are physicians not morally or legally bound, but that they further have a social and moral duty not to administer futile medical measures for the following reasons:

(1) It would be an irresponsible waste of resources, especially where nations follow a rationing system

(2) Patients with means would simply change doctors or institutions until they found one who would provide the futile treatment, thereby undermining the futility paradigm, as well as needed uniform medical standards in societies.

(3) Providing a futile treatment would give false hope to the patient and family, leading to inevitable disappointments and, at the same time, creating false expectations in the general community regarding what scientific medical advances are able to achieve.³⁵

These arguments can also be applied to sub-Saharan African nations and communities in their effort to provide health care to AIDS end-stage terminal illnesses. In the above discussion on futile medical treatment, the focus is on the physician who determines whether a treatment is quantitatively futile and the patient who determines whether a treatment is burdensome or qualitatively futile. However, in the context of sSA where the government and communities bear the burden of paying for HIV/AIDS treatment, the understanding of medical futility needs to be expanded to incorporate the perspective of the one allocating resources in order to pay for the treatment.

This is similar to the situation of an insurance company examining a treatment and designating it experimental, and therefore, not covered. Similarly, it is akin to socialized medicine in Canada or the United Kingdom, where the government determines what procedures will be covered, by means of treatment rationing. However, the need to draw futility distinctions in sSA based on communal costs versus patient benefits is significantly elevated because of the extreme poverty, the high percentage of HIV/AIDS infection as well as other diseases, such as malaria and tuberculosis, and the resulting drain they have on the limited resources of sSA communities and governments.

IV. sSA Economic Conditions

Africa starts the 21st century as the poorest, the most technologically backward, the most debt distressed, and the most marginalized region in the world. It accounts for 12.5% of the world's population but produces only 3.7% of global GDP.³⁶

The biggest challenge facing sSA countries is allocation of limited resources. Major problems include fighting containable insect-borne and communicable diseases such as malaria and tuberculosis; treating nutrition-related illnesses; fighting the AIDS epidemic; treating HIV/AIDS victims; and building an infrastructure that will allow for increased economic growth and education. In order to comprehend the magnitude of this challenge, it is necessary to understand the present economic conditions of sSA countries.

Fourteen of the world's poorest countries are in sSA. The gross national product per capita in sSA ranged from US\$130 to US\$200.³⁷ In

the early 1990s, the economic growth rate of this region averaged 1.5%, the lowest in the world.³⁸ In 1995, fifty-two percent of sSA's population survived on one dollar per day.³⁹ As a result of the extreme poverty of this region, malnutrition-related illnesses are commonplace. "Chronic protein and micronutrient malnutrition is associated with stunting and wasting and with many diseases, some of them deadly: blindness, chronic diarrhea, acute respiratory infections, goiter, anemia, and more."⁴⁰ Seventy percent of the population depends on agriculture for their livelihood, yet over the past fifty years, more than 650 million square kilometers of farmland have been lost to desertification.⁴¹ Even with the devastation the AIDS epidemic has inflicted on the population of the area, the population continues to grow at a rate faster than any other developing region: 3.2% as compared to 2.1% in Latin America and 1.8 in Asia.⁴² The educational system is virtually nonexistent for the majority of the children in sSA. Eighty million children have no access to elementary school and only 2% of the population attends institutions of higher education.⁴³ The drain on this region's resources is further complicated by the high incidence of malaria infections, which kills more than one million people in sSA annually, and tuberculosis, which infected 864,000 sSA people in 1999 alone.⁴⁴

In short, sSA populations are poor and the government resources available to assist citizens are insufficient to meet even the more fundamental needs such as food and education. Against this backdrop, the HIV/AIDS epidemic continues to devastate the population of sSA. In 2000 alone, 2.4 million people in sSA died of AIDS-related illnesses, while another 3.4 million became infected.⁴⁵ UNAIDS estimates that there are 34 million people infected with the HIV/AIDS virus. Of that number, 23 million live in sSA.⁴⁶ The impact on the families of AIDS victims is not limited to emotional impact. For example, it is estimated that by 2005, 4.2 million sSA children will be orphaned as a consequence of AIDS.⁴⁷ Not only does AIDS result in people being widowed and orphaned, but perhaps more significantly is the financial toll as a family's income is typically reduced by more than half when the infected member becomes disabled or dies.⁴⁸

In addition to its impact on families, the AIDS epidemic is also affecting the economic growth of these countries. One report estimates that the AIDS epidemic will be the decisive factor in these already impoverished economies, which are expected to shrink by approximately 25% over the next 20 years. Further, the potential to develop is being devastated in these countries. The impact on the labor force alone is terrible. For example, the life expectancy of the average sSA worker has declined by more than 20 years because of the AIDS crisis. Consequently, the ability for firms to compete has been significantly compromised because of the increased expenditures due to increased health care costs and the need to replace

employees. At the same time, revenues are decreasing because of the effect that absenteeism and allocation of resources to employee training are having on productivity.⁴⁹

One of the many problems facing sSA is the cost of drugs that are used to treat AIDS patients. Merck and Bristol-Meyers have cut their prices in order to make AIDS drugs more affordable in sSA.⁵⁰ AIDS cocktails in sSA now cost US\$500-600 per person per year.⁵¹ An Indian-based generic drug manufacturer, Cipla, Ltd., now offers generic versions of eight of fifteen HIV cocktail drugs to sSA governments at an even more reduced price of \$350 per person per year.⁵²

V. Application of the Principles of Ordinary and Extraordinary Treatment and Medical Futility to HIV/AIDS in sSA

A person is regarded as having AIDS when his or her CD4+ cell count drops below 200 cells/mm³ of blood count (normal CD4+ count is 1000) or when CD4+ cells comprise less than 14% of the individual's total lymphocytes.⁵³

Standard treatment in Western countries for HIV/AIDS patients is a 15 drug regimen known as the AIDS cocktail, which has proven to reduce transmission of the HIV virus. The cocktails are grouped into three classes: nucleoside reverse transcriptase inhibitors (NRTIs), nonnucleoside reverse transcriptase inhibitors (NNRTIs), and protease inhibitors (PIs).⁵⁴ Because of the patient's deteriorating immune system, the patient is at risk for contracting opportunistic diseases seldom seen in individuals with healthy immune systems. Use of the cocktail during this phase can help to elevate white blood cell levels, thereby slowing the deterioration of the immune system. It has proven to be an effective treatment for prolonging HIV/AIDS patients' lives. However, the cocktail regimen's side effects are similar to that of chemotherapy and unlike cancer treatment, the cocktail has to be taken for the duration of the AIDS patient's life.

As already stated, this treatment is expensive. For sSA populations, even having access at the reduced prices now available, the cocktail is still cost prohibitive. The alternative to the cocktail is the use of a single drug and this approach has proven to be ineffective because of the speed with which the body becomes resistant to the drug. At most, use of a single drug showed an effectiveness of one to two years. Understanding the cost and effectiveness of treatment is critical in determining whether the available treatments should be considered ordinary or extraordinary in the contexts of AIDS in sSA. So far, almost no attention has been given to this important and challenging project of assisting communities to come up with medical spending decisions.

Other components are also necessary in evaluating how AIDS treatment should be categorized. Because of the impoverished conditions of these communities, there is no guarantee of supply. Once a person starts taking the cocktail, or even an individual drug, it is important that the patient remain faithful to the regimen because otherwise resistance to the drug(s) will develop. As a result, should the patient resume treatment, the effectiveness of the regimen is reduced. Also, even if supply can be guaranteed, the impoverished conditions of most AIDS patients in sSA coupled with their lack of education and the harshness of the side effects of the drug(s) makes it questionable whether the patients themselves will be faithful to the regimen. Finally, the lack of infrastructure and skilled medical personnel makes it difficult for patients on the drug regimen to have the necessary access to medical resources that will allow them to receive follow-up medical care and consultation. The depletion in medical personnel is due to many doctors and nurses leaving sSA to practice in Western countries. Many of those who remained have, themselves, fallen victim to the AIDS epidemic. In fact, access to doctors is so limited that, in this commentator's personal experience, it is not uncommon for nurses in sSA to prescribe medication.

Applying the ordinary/extraordinary principles to the reality of AIDS in sSA, treatment for AIDS either using the cocktail or even the individual drug regimen should be termed extraordinary treatment. The fact that even using the most effective treatment currently available can only guarantee the progress of the disease will be delayed and the fact that the treatment must be taken for life strongly supports this position. The cost of the treatment is depleting the meager resources of families, communities, and governments. Other pressing concerns affecting the entire population are at risk of being abandoned because of the high cost of treatment.

Applying the guidelines provided above, it is the moral responsibility of all people to seek that care which is reasonable under the circumstances. One element in determining what is reasonable is the burden the treatment places on those for whom the patient is responsible. Given the economic conditions in sSA, the burden on family and community is too great for it to be moral to divert resources to the treatment of HIV/AIDS patients. If a patient without financial resources seeks out treatment at the communities' expense, then it becomes the responsibility of the community to withhold the finances needed to obtain treatment.

If the present drug regimens are deemed extraordinary, then what treatment is ordinary? The treatment that is considered to be ordinary is that treatment which is within the financial means of the community, taking into consideration the needs of the community. In the situation of sSA, ordinary means would be those pain medications financially affordable,

that will enable the AIDS patient to be as comfortable as possible and when the end comes, help the person to die in comfort and with dignity.

This position is equally supported by the medical futility principle. As previously stated, a treatment is medically futile if it is unable to achieve its intended end or if its burden on the patient outweighs the benefits. While most scholars focus on the physician and the patient as determining which treatment is futile, in the case of sSA, I would expand this to include the financier of the treatment, in most cases the family and/or the government. I would also add as a component of medical futility the burden to the community in light of the present inability to cure the patient of the illness.

It is clearly established that the cost of the cocktail makes that treatment unaffordable for sSA populations. Even if it could be made affordable, issues of supply and willingness to remain faithful to the treatment make it highly improbable that the treatment is able to achieve its intended purpose, substantial prolongation of life. The use of a single drug is of greater futility because even under the best of circumstances, its benefits to the patient are minimal. The cost to the family and community, however, continues to be disproportionately high.

In the event a cure is found, the analysis would be different. While the cost would certainly be high, it would not entail a commitment to a treatment lasting the lifetime of each AIDS patient in a given community. Also, the ability for each of these individuals to return to a productive condition because of being cured would change the equation. However, given the high numbers of infected individuals, 23 million as of the year 2000, even in the event of a cure, difficult decisions would most likely need to be made as to priority of receipt of treatment. The high cost associated with distributing any curative treatment and the fragile and impoverished infrastructure of these regions would certainly require somebody having to decide who will receive the curative treatment to live and who will be left to die.

VI. Conclusion

The problem of HIV/AIDS in sSA is challenging the traditional ways of caring for terminally ill patients. One of these challenges in providing health care, especially to AIDS victims, is the problem of cost containment.

This paper has discussed the application of the Catholic Church's casuistic method of ordinary and extraordinary medical procedure as one of the ways sSA communities and governments can solve the problem of cost containment. We have argued that the ordinary means of caring for terminal AIDS patients is pain relief medical care. AIDS patients are intrinsically valuable even when they are dying. While we cannot dispute this fact, according to the traditional Catholic teaching on prolonging life,

there are times when human life must be sacrificed for other goods. For example, there is no moral obligation to continue disproportionate high-cost treatments if there is no hope of a cure. At times, death becomes something we might choose rather than something that happens to us. To date, the question of what treatment obligations are owed to AIDS victims is one that has been ignored by both the governments and the religious communities. Most pastoral letters issued by the Catholic Church, for example, deal with the morality of condom use and sexual promiscuity.⁵⁵ However, to date, no Bishops' Conference has addressed the morality issue concerning whether it is necessary to provide treatment to AIDS victims at the cost of further depleting the already scarce resources of the communities.

A comprehensive approach to providing medical care to the AIDS epidemic in sSA must not only address moral and social issues. Economic issues, such as planning medical spending decisions, must be regarded as very critical especially at this time when there is no vaccine or cure for HIV/AIDS. In failing to do this, the results will jeopardize everything the economically disadvantaged societies of sub-Saharan Africa have achieved ever since the end of colonial political, economic, and religious domination.

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